"Near Miss" Report

A key component of improving safety is to proactively identify hazards that have the potential to result in harm. Your input is important to ensuring a safe environment for all. A "near miss" or "close call" is defined as an event that could have resulted in harm to the patient, but did not, either by chance or timely intervention. The event was identified & resolved before reaching the patient.

This is a "no blame" process of reporting potential hazards. Our goal is to focus on preventing and minimizing future risk. This is an opportunity to FIX the system before it breaks, recognize symptoms of broken processes, prioritize the level/extent of the inquiry and then recommend improvements.

THANKS for taking time out of your busy day to share your observations and suggestions to improve patient safety!

**This form can be filled out anonymously!

Basic Information:
Location of Event: _____
_____
_____
Time: _____
Department(s) Involved in the Near Miss: _____
_____
_____
_____

You may contact me if you have any questions related to this PS event. .
Yes _____ No _____
Name: _____
E-mail: _____
Phone _____

Report of Incident:
Describe what happened. Include what the potential danger is/was. Could people have been hurt, could equipment have been damaged or mission affected? Attach additional sheets if necessary.

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Corrective Action:
Please suggest any corrective actions or recommendations for improvement learned from this incident. Attach additional sheets if necessary.

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